HOUSE OF OPTICAL

Patient Information

Name (legal):

Preferred First Name:

Date of Birth:

Gender (circle): Male Female

Ethnicity:

Street Address:

City: State: Zip:

Primary Phone Number:

Secondary Phone Number:

Email Address:

Employer:

Occupation:

Primary Care Physician:

Are you interested in any of the following?

Contact lenses?	Y N
Computer glasses?	Y N
Safety glasses?	Y N

Do you experience any of the following?

Blurred vision	Y N
Double vision	Y N
Loss of vision	Y N
Floaters	Y N
Flashes of light	Y N
Dry eye/Eye irritation	Y N
Itchy/Watery eyes	Y N
Mucous/Discharge	Y N
Foreign body sensation	Y N
Sensitivity to light	Y N
Headaches	Y N
Eye pain	Y N

List current/previous eye injury, disease, or surgery:

Medical History

Diabetes	Y N	Bladder/Urinary Tract	Y N
Blood Pressure	Y N	Heart Disease	Y N
Cholesterol	Y N	Stroke	Y N
Thyroid Disease	Y N	Gastrointestinal	Y N
Arthritis	Y N	Acid Reflux	Y N
Allergy/Sinusitis	Y N	Respiratory/Asthma	Y N
Cancer	Y N	Ear/Nose/Throat	Y N
Skin Disorder	Y N	Blood Disease	Y N
Depression/Anxiety	Y N	Muscle Disease	Y N
Neurological	Y N	HIV	Y N
Migraines	Y N		

Other:

List Current Medications:

List any medications you are allergic to:

List any non-medical allergies:

Do you smoke cigarettes?	Y N
Do you consume alcohol?	Y N
Are you pregnant/nursing?	Y N

Family Medical History

Diabetes	Y N
Cancer	Y N
Macular Degeneration	Y N
Cataract	Y N
Glaucoma	Y N

For staff use only

EG Rx:

CL Rx:

By signing below, I certify that the information on this form is accurate to the best of my knowledge:

Patient Signature: _____

Date: _____

Eye Health Screening Tests

A new sophisticated, computerized instrument now allows the doctor to provide a more thorough analysis of your eye and visual pathway. The results of these tests can assist in detection of brain tumors, diabetic retinopathy, glaucoma, stroke, and other disorders. These tests are strongly recommended by medical professionals, especially patients with the following conditions: headaches, diabetes, flashes of light, strong glasses prescriptions, and family history of eye disease.

Retinal Photo Screener **Y N**
(advanced digital retinal photos)

Visual Field Test: **Y N**

Both tests: $30 Retinal Screen: $20 Visual Field: $15

Consent & Authorization

I authorize House of Optical to release any medical or other information necessary to process this insurance claim for vision/medical services.

I authorize my insurance company to pay House of Optical for the optical/medical services rendered. I also understand if my deductible has not been met that my claim may be rejected and I will be responsible for any unpaid balances. If your insurance denies payment for services rendered for any reason, we will bill you directly and payment is expected within 30 days. There is a $25 charge for all returned checks.

Patient Signature: _____

Date: _____

Privacy Practices & Notices

By signing below, I acknowledge and understand the office's Notice of Privacy Practices. I acknowledge that I have received a copy of my contact lens prescription upon finalization of the prescription.

Patient Signature: _____

Date: _____